



Health Care Fraud and Program Integrity

An Overview for Providers



Objective

To present a general overview of Medicaid fraud and abuse and program integrity measures.

PROGRAM INTEGRITY

~~**FRAUD**~~

~~**ABUSE**~~

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Goals

- Recognize at least two types of Medicaid fraud or abuse
- Identify two laws against Medicaid fraud and abuse
- Recall two Medicaid anti-fraud measures taken by the government
- Recall two steps that may be taken to prevent fraud, waste, and abuse
- Describe how to report Medicaid fraud, waste, or abuse

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Medicaid

The Medicaid program:

- Covers medical expenses for more than 57 million beneficiaries each year through 56 State and territory-administered programs
- Cost \$427 billion in 2011
- Made improper payments of \$21.9 billion in 2011



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Improper Payments

- Divert resources away from necessary care
- May subject health care professionals to recoupment and other sanctions



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Waste

- Waste can be defined as overutilization or inappropriate utilization of resources
- Waste typically is not an intentional act

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Abuse

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in:

- Unnecessary cost to the Medicaid program, or
- Reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care

It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

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Fraud

Fraud is:

- An intentional deception or misrepresentation
- Made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person

It includes any act that constitutes fraud under applicable Federal or State law.

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Types of Fraud and Abuse

Common types of health care fraud and abuse include:

- | | |
|--|---------------------------------|
| • Medical identity theft | • Unbundling |
| • Billing for unnecessary services or items | • Non-covered services or items |
| • Billing for services or items not provided | • Kickbacks |
| • Upcoding | • Beneficiary fraud |

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Medical Identity Theft

Medical identity theft has been defined as:

- The appropriation or misuse of a patient's or provider's unique medical identifying information to obtain or bill public or private payors for fraudulent medical goods or services



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Medical Identity Theft—Former Director of a Medical Clinic in Michigan

- Stole provider and beneficiary identities
- Continued to submit claims for 4 years after the clinic had closed
- Billed Medicaid \$3.3 million
- Convicted in October 2011
- Sentenced to 4 years in prison

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Medical Identity Theft—Owner of an Oklahoma Prosthetics Laboratory

- Stole physician medical identities
- Billed Medicaid for prosthetic limbs
- Sentenced to 4 years and 3 months in prison
- Ordered to pay \$4.6 million in restitution



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Medical Identity Theft Bronx Resident

- Stole prescription paper and Medicaid cards
- Forged prescriptions for painkillers
- Billed prescriptions to Medicaid for more than \$200,000
- Received a 4- to 8-year prison sentence



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Medical Identity Theft Ophthalmologist in Washington State

- Used patient information to bill for services never furnished from 2002 through 2008
- Pleaded guilty to stealing \$51,000 from Medicare and Medicaid
- Received a sentence of community service and restitution



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Medical Identity Theft Prevention

- Manage enrollment information with payors
- Monitor billing and compliance processes
- Control unique medical identifiers and prescription pads
- Educate and train staff
- Engage patients about the risks of medical identity theft



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Billing for Unauthorized or Unnecessary Services or Items

- Each State defines what services or items are authorized by Medicaid
- Some services or items are only authorized if medically necessary
- Health care professional's signature certifies truth and completeness of the claim



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Billing for Unnecessary Services or Items—Maryland Cardiologist

- Placed unnecessary cardiac stents from 2003 through 2007
- Performed unnecessary tests
- Billed Medicare, Medicaid, and private insurers
- Received a sentence of 8 years and 1 month in prison
- Was ordered to pay \$597,070 in restitution

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Unnecessary Services Dallas Physician

- Wrote unnecessary prescriptions for painkillers from 2010 to 2011
- Ordered unnecessary diagnostic tests
- Billed the cost of the prescriptions and tests to Medicare and Medicaid
- Pleaded guilty to conspiracy to commit health care fraud
- Was sentenced to 48 months in Federal prison

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Billing for Services Not Rendered Massachusetts Personal Care Attendant

- Signed false time records for care on dates when the beneficiary was
 - In the hospital
 - Deceased
- Billed Medicaid for these services
- Received a 2-year sentence of probation
- Was ordered to pay \$10,000 in restitution



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Billing for Services Not Rendered Atlanta Physician

- Did not provide claimed psychological therapy to nursing home patients
- Billed Medicare and Medicaid almost \$1 million
- Pleaded guilty to health care fraud
- Was sentenced to 1 year and 3 months in prison
- Was ordered to pay almost \$1 million in restitution



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Billing for Services Not Rendered Missouri Psychologist

- Forged sign-in sheets
- Billed Medicare and Medicaid for \$1 million
- Was sentenced to 3 years in prison



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Billing for Services Not Rendered Georgia Nursing Home Owner

- Received \$32.9 million from Medicare and Medicaid
- Provided a near-starvation diet for nursing home residents
- Maintained unsanitary conditions
- Received a 20-year prison sentence

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Billing for Items Not Provided Company Manager

- Billed for durable medical equipment (DME) not provided
- Received \$3.8 million from Medicaid
- Sentenced to 3 years and 1 month in prison



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Upcoding

- Billing simple tooth extractions as surgical extractions or post-surgical complications
- Billing for a power wheelchair and supplying a less expensive model
- Billing simple office visits as complex visits



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Unbundling

- New York dental clinic
 - Cleanings, examinations, and X-rays billed separately
 - \$325,000 settlement
- Health care systems
 - Infusion therapy
 - \$2 million settlement
- Laboratories
 - Test panels

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Billing for Non-Covered Services Mississippi Physician

A Mississippi physician who owned a physical therapy company:

- Billed Medicare and Medicaid for physical therapy performed by unqualified persons
- Was sentenced to 14 years in prison
- Was ordered to pay more than \$6.9 million in restitution

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Non-Covered Services or Items New York Executive

The chief executive officer of a New York DME company:

- Billed more than \$1 million for non-covered shoe inserts and shoes between 2006 and 2010
- Pleaded guilty to conspiracy to commit health care fraud
- Faces imprisonment for up to 10 years

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Kickbacks

A kickback is defined as:

- Soliciting, offering, paying, or receiving remuneration (in kind or in cash) to induce or in return for referral of individuals, goods, or services for which payment may be made under a Federal health care program



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Kickbacks New Jersey Physician

- Referred Medicare and Medicaid patients for medical imaging scans
- Received payments for referrals
- Pleaded guilty to violation of the Anti-Kickback Statute
- Sentenced to 6 months in prison, 6 months of home detention, and 2 years of supervised release

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Kickbacks Alabama Company Owner

The owner of an Alabama hemophilia care company:

- Received payments for a percentage of profits on prescriptions filled
- Ordered more medicine than was medically necessary
- Billed Medicaid for cost of medicine
- Pleaded guilty to violation of the Anti-Kickback Statute
- Was sentenced to 2 years and 3 months in prison
- Was ordered to pay a \$1.75 million fine

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Kickbacks Brooklyn Dentist

- Paid patient recruiters to obtain patients by paying them to visit
- Recruited patients from homeless shelters and soup kitchens
- Billed Medicaid for office visits
- Pleaded guilty to health care fraud and other offenses
- Paid nearly \$700,000 in restitution
- Was sentenced to 1 to 3 years in prison

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True or False?

Three common types of Medicaid provider fraud are:

- Billing for unnecessary services or items
- Billing for services or items not rendered
- Upcoding

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Beneficiary Fraud

- Eligibility fraud
- Card sharing
- Doctor shopping
- Drug diversion



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Drug Diversion Michigan Pharmacy Owner

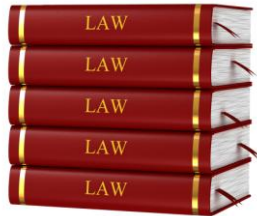
- Paid kickbacks to physicians to prescribe without medical necessity from 2006 through 2011
- Dispensed controlled substances as kickbacks to patients
- Billed Medicaid for unnecessary prescriptions and other prescriptions that were never filled
- Was found guilty of health care fraud and other offenses
- Was sentenced to 17 years in prison

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Laws Against Health Care Fraud

- Health care fraud statute
- False Claims Act
- Anti-Kickback Statute
- Exclusion provisions of the Social Security Act
- Civil Monetary Penalties Law



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Health Care Fraud Statute

The health care fraud statute:

- Prohibits knowingly and willfully executing a scheme to defraud a health care benefit program
- Punishes violations with up to 10 years' imprisonment and up to \$250,000 in fines
- Does not require proof of specific intent to violate the statute



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False Claims Act

The False Claims Act establishes civil liability for knowingly presenting a false or fraudulent claim to the government for payment. No specific intent to violate the Act is required for conviction.

Consequences may include:

- Civil penalties of up to \$11,000 per claim
- Treble damages
- Exclusion



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False Claims Criminal Provisions

Persons who knowingly make a false claim may be criminally prosecuted. Punishment may include:

- Fines up to \$250,000
- Up to 5 years' imprisonment



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Referral Fees or Kickbacks Prohibited

The Anti-Kickback Statute prohibits:

- The knowing and willful offer, payment, solicitation, or receipt of any remuneration, in cash or in kind, to induce or in return for referral of individuals, goods, or services for which payment may be made under a Federal health care program



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Kickbacks Consequences

The consequences of kickback violations may include:

- Criminal penalties:
 - Up to 5 years' imprisonment
 - Payment of a fine up to \$25,000
- Civil penalties:
 - Payment of up to \$50,000 per violation
 - Payment of three times the amount of remuneration
- Exclusion from Federal health care programs

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Exclusion Provisions Authority

The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), has the authority to exclude individuals and entities from participation in Federal health care programs for various reasons, including:

- Conviction of certain criminal offenses
- Loss of license for reasons of professional competence or financial integrity
- Participation in prohibited conduct

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Exclusion Provisions Effect

- Federal health care programs should not be billed for items or services furnished, ordered, prescribed, or supplied by an excluded individual or entity
- Payments for such items or services are considered overpayments that must be returned within 60 days of the date they are identified
- Failure to return these overpayments may lead to liability under the False Claims Act and the Civil Monetary Penalties Law

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Civil Monetary Penalties Law

The Civil Monetary Penalties Law gives HHS-OIG authority to impose civil penalties for certain prohibited acts, including but not limited to:

- Violations of the Anti-Kickback Statute and the exclusion provisions
- False claims
- False statements on applications or contracts for a Federal health care program

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True or False?

Federal laws against health care fraud include:

- The health care fraud statute
- The False Claims Act
- The Anti-Kickback Statute

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Prevention

Health care professionals can help prevent fraud, waste, and abuse by:

- Knowing the regulations and laws governing the services offered by the practice
- Screening potential and existing employees and contractors for exclusions by checking the List of Excluded Individuals/Entities (LEIE) database at https://oig.hhs.gov/exclusions/exclusions_list.asp on the HHS-OIG website
- Ensuring that services provided are medically necessary or otherwise authorized under State Medicaid requirements
- Using sound billing practices

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Prevention— Compliance Program

A compliance program may consist of:

1. Implementing written standards and procedures
2. Designating a compliance officer or contact(s) to monitor compliance
3. Conducting training and education on standards and procedures
4. Developing open lines of communication
5. Enforcing disciplinary standards through well-publicized guidelines
6. Conducting internal monitoring and auditing
7. Responding appropriately to detected violations

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True or False?

Steps that health care professionals may take to prevent fraud, waste, and abuse include:

- Implementing written standards and procedures
- Conducting training and education on standards and procedures
- Developing open lines of communication
- Conducting internal monitoring and auditing

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Recoveries and Prosecutions

In fiscal year 2012:

- More than \$4 billion was recovered by the Federal government in health care fraud cases
- State Medicaid Fraud Control Units (MFCUs) recovered \$2.9 billion for the Medicaid program in civil and criminal cases

In fiscal year 2011:

- 1,430 defendants were charged with health care fraud related crimes

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Identification of Improper Medicaid Payments

- Payment Error Rate Measurement program
- Audit Medicaid Integrity Contractors
- Medicaid Recovery Audit Contractors



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Anti-Fraud Efforts

Anti-fraud efforts undertaken or overseen by CMS' Center for Program Integrity include:

- Tracking medical identity theft
- Offering identity theft remediation
- Using predictive modeling
- Screening providers at enrollment
- Suspending payments upon a credible allegation of fraud
- Terminating providers for cause

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Screening of Providers

Medicaid rules require screening of providers for:

- Current licensure
- Exclusion
- Termination for cause

If a provider has previously been excluded, terminated, or suspended, the provider may also be subject to:

- A criminal background check
- Fingerprinting

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Suspension of Payments

States are required to suspend Medicaid payments to providers when there is:

- A credible allegation of fraud and a pending investigation



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Reciprocal Termination

States must terminate a provider from Medicaid if the provider has been terminated for cause by:

- Another State's Medicaid program
- Another State's Children's Health Insurance Program (CHIP), or
- Medicare

For cause means for reasons of:

- Fraud
- Integrity
- Quality



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True or False?

Anti-fraud measures taken by the government include:

- Tracking medical identity theft
- Screening providers at enrollment
- Suspending payments upon a credible allegation of fraud

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How to Report Fraud, Waste, or Abuse

Report suspect practices to:

- The State Medicaid agency (SMA)
- The Medicaid Fraud Control Unit (MFCU)
 - Contact information for SMAs and MFCUs is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforConsumers/Downloads/smafraudcontacts-february2014.pdf> on the CMS website
- HHS-OIG
 - 1-800-HHS-TIPS
 - <https://forms.oig.hhs.gov/hotlineoperations/>

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True or False?

A health care professional can report suspected Medicaid fraud, waste, or abuse to:

- The SMA
- The MFCU
- HHS-OIG

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Conclusion

By following program rules, taking reasonable preventive measures, and recognizing and reporting suspected fraud and abuse, health care professionals:

- Protect their practices
- Protect beneficiaries from harm
- Help preserve the solvency of the Medicaid program

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Questions



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